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GAO Audit Reports

GAO Audits

1. COMBATING TERRORISM: Chemical and Biological Medical Supplies are Poorly Managed (GAO/HEHS/AIMD-00-36), October 29, 1999:

RESPONSIBLE ORGANIZATIONS: Veterans Health Administration

RECOMMENDATION:

To address the internal control weaknesses identified in this report, GAO recommends that the Department of Health and Human Services' Office of Emergency Preparedness, the HHS Centers for Disease Control and Prevention, the Marine Corps Chemical and Biological Incident Response Force, and the Department of Veterans Affairs establish sufficient systems of internal control over their chemical and biological stockpile management. The agencies need to reasonably assure that personnel carry out the following specific control activities:

- Conduct risk assessments and organize program activities to identify and mitigate risks.

ACTIONS TAKEN:

- The Office of Emergency Preparedness (OEP), Health and Human Services, contracted a consultant, Logistics Management Institute to conduct a risk assessment of each cache storage site. The risk assessment was conducted with the assistance of OEP and VA and completed in August 2000. The VA began making recommended changes immediately to reduce risk. These changes were reflected in the consultant's final report. VA will move one cache to a new storage location in April 2001, to complete one recommendation. The remaining incomplete recommendations are pending OEP approval for implementation. VA is organizing an internal team to conduct the next risk assessment during 2001. Target Date: July 1, 2001.

RECOMMENDATION:

- Arrange for periodic, independent inventories.

ACTIONS TAKEN:

- Four complete inventories of each cache were conducted during calendar year 2000 with assistance from OEP, the Emergency Management Strategic Healthcare Group, and the Office of Acquisition and Materiel Management. OEP has determined that one complete inventory of each cache should be conducted in calendar year 2001; currently, that action will be addressed later in the year. This item is closed.

RECOMMENDATION:

- Implement a tracking system that retains complete documentation for all supplies that have been ordered, received, and destroyed.

ACTIONS TAKEN:

- VA implemented a system that meets all product tracking requirements. The system was implemented in January 2000, and verified in April 2000. This item is closed.

RECOMMENDATION:

- Rotate supplies properly.

ACTIONS TAKEN:

- Product rotations were conducted during each cache visit for inventory purposes in calendar year 2000. During the last inventory, there were no outdated products in the caches. This item is closed.

BUDGET IMPLICATIONS: None.

2. GULF WAR ILLNESSES: Management Actions Needed to Answer Basic Research Questions (GAO/NSIAD-00-32), January 6, 2000:

RESPONSIBLE ORGANIZATIONS: Veterans Health Administration

RECOMMENDATION:

With response to the health research efforts coordinated by the Research Working Group of the Persian Gulf Veterans' Coordinating Board, GAO recommends that the Secretaries of Veterans' Affairs, Defense, and Health and Human Services direct the executive director of the Research Working Group to:

- Establish and achieve a target date within fiscal 2000 for publishing its assessment of progress toward addressing the research objectives it identified in 1995.

ACTIONS TAKEN:

- Dr. John Feussner is the Chair of the Research Working Group. This group of scientists has worked to plan and write a series of technical reports. These reports focus on the scientific evidence, related to each of the 21 research objectives identified in 1995. Each research objective has been addressed by one or more funded projects in the Gulf War research portfolio, which currently includes 192 projects. The group is in the process of preparing these reports for publication in a medical journal.

BUDGET IMPLICATIONS: None.

RECOMMENDATION:

- Compile data on the number of Gulf War veterans with unexplained illnesses, the progression of their illnesses, the treatments they are receiving, and the success of these treatments (recognizing that application of some working case definitions or categorization scheme may be useful for purposes of such an accounting).

ACTIONS TAKEN:

- VHA has taken significant action in support of this recommendation. There are a number of ongoing studies, which, when they are completed, will allow us to compile data to increase our understanding of unexplained illnesses in Gulf War veterans. For instance, in the National Academy of Science's Institute of Medicine (IOM) 1999, report *Gulf War Veterans, Measuring Health*, the IOM

concluded that the best way to evaluate the health consequences of service in the Gulf War is through the use of well-designed epidemiologic studies. In order to answer fundamental questions about the health of Gulf War veterans over time, IOM also reported that a prospective cohort study based on comparison to an appropriate control baseline group is needed. Coordinating through the Research Working Group (RWG), VA, the Department of Defense (DoD), and the Department of Health and Human Services (HHS) are responding to the IOM recommendation by implementing a longitudinal cohort study. Last year, a study proposal submitted to a national program that utilizes a level of scientific peer review equivalent to that of VA, scored favorably. We anticipate that the proposal will be granted VA research support and funding this summer, and will produce high quality results relevant to Gulf War veterans' health care needs consistent with the IOM recommendation.

BUDGET IMPLICATIONS: We anticipate that the proposal will be granted VA research support and funding this summer.

RECOMMENDATION:

- Effectively coordinate the efforts of the Office of the Special Assistant for Gulf War Illnesses with related activities of DoD, VA, and HHS to prevent duplication and improve the efficiency for resource use.

ACTIONS TAKEN:

- We continue to non-concur with this recommendation. The RWG has previously provided sufficient information on the scope and coordination of its activities with other federal agencies, including DoD's Office of the Special Assistant for Gulf War Illnesses. By drawing together VA, DoD, and HHS, the RWG has been able to develop an overall research strategy; serve as a common forum for researchers to present ideas and findings; and collectively respond to emerging research issues and problems. All projects and their categories are described in complete detail in the Annual Report to Congress, which the RWG is responsible for preparing. This kind of collaboration within the federal medical and research communities is consistent with that which was recommended by GAO.

BUDGET IMPLICATIONS: None.

3. ACQUISITION REFORM: GSA and VA Efforts to Improve Training of Their Acquisition Workforces (GAO/GGD-00-66), February 18, 2000:

RESPONSIBLE ORGANIZATION: Office of Acquisition and Materiel Management

RECOMMENDATION:

To ensure that the skills of their acquisition workforces are current, GAO recommends that the Administrator of GSA and the Secretary of Veterans Affairs fully adhere to the Office of Federal Procurement Policy's (OFPP) policy associated with Clinger-Cohen's training provisions by (1) establishing core training requirements for all contracting officer representatives and contracting officer technical representatives; (2) ensuring that all acquisition personnel receive the required core training and continuing education, consistent with OFPP's policy; (3) directing appropriate agency personnel to collect and maintain accurate and up-to-date data showing the extent to which acquisition personnel meet training requirements; and (4) seeing that all funding that agencies plan to use for educating and training their acquisition workforces is identified in appropriate budget documents and that all related expenditures for such education and training are tracked.

ACTIONS TAKEN:

- VA established a training requirement for contracting officer technical representatives (COTRs) in November 1999. The November 1999, policy states VA COTRs must receive training that covers the competencies identified in the Federal Acquisition Institute (FAI) Contracting Officer Representative (COR) Workbook. The policy encourages COTRs to complete FAI's online COR Mentor Acquisition and Materiel Management Web site. The COTR training requirement was recently reinforced, via a Department-wide e-mail to the VA Acquisition mail-group.

- To help ensure more acquisition workforce members receive required core training and continuing education, in 2000, the Office of Acquisition and Materiel Management increased enrollments in its two, supplemental continuing education programs and added one supplemental acquisition course. This year, OA&MM is piloting an additional supplemental training course. VA acquisition workforce members continue to be encouraged to enroll in and complete acquisition training offered on the FAI Online University.

- To facilitate VA's collection and maintenance of accurate and up-to-date data showing the extent to which acquisition personnel meet training requirements,

OA&MM has purchased a commercial application that will capture training and education data for VA's acquisition workforce. The application is being customized for VA use and will be accessible to VA's acquisition workforce later this fiscal year. Acquisition workforce members and acquisition managers are also regularly reminded to ensure training and education data is included in personnel files.

- The funds OA&MM expends to educate and train VA's acquisition workforce is identified as a Supply Fund line item in VA budget documents. Expenditure of these funds is monitored and tracked by OA&MM.

BUDGET IMPLICATIONS: None.

4. WHISTLEBLOWER PROTECTION: VA Did Little Until Recently to Inform Employees About Their Rights (GAO/GGD-00-70), April 14, 2000:

RESPONSIBLE ORGANIZATION: Assistant Secretary for Human Resources and Administration

RECOMMENDATIONS:

GAO recommends that the Secretary of Veterans Affairs establish a long-term plan of intended actions with target dates for (1) informing on a periodic basis all employees of their whistleblower rights; and (2) measuring the effectiveness of such actions, such as with a periodic survey of employees.

GAO also recommends that the Secretary design and implement a system for tracking overall whistleblower complaints; complaints for which reprisal was determined or the complaint was settled; and what actions, if any, VA took against VA managers when reprisal was found to have occurred. In addition, GAO recommends that VA analyze these data periodically to ascertain whether additional steps are needed to ensure that reprisal is not tolerated.

ACTIONS TAKEN:

- VA has implemented or taken steps to implement the above recommendations. As indicated in the GAO report, the Department has already taken a number of actions to promote a culture where employees feel free to come forward with their legitimate concerns without fear of reprisal. As shown below, VA's long-term plan of intended actions addresses GAO's recommendations and involves continuation of already implemented actions. It also includes the implementation of actions that are currently under development or planned for the future.

- Action Plan:

A. Continuation of Actions

- Maintenance of information on VA Web sites, with links to the Office of Inspector General and Office of Special Counsel (OSC). The Office of Human Resources Management web site includes a Microsoft Powerpoint presentation that can be downloaded and used for training purposes;

- Information provided at the facility level, on whistleblower protections in a variety of media such as employee orientation material and handbooks; information posted in prominent, highly visible public locations; discussion of

employee rights and responsibilities in local e-mails and newsletters; and in-house training for managers and supervisors;

- Rapid Response Investigative Teams are being deployed to review allegations of serious misconduct against VA senior managers, including those involving whistle-blowing retaliation;

- General Counsel established a formal protocol and liaison between VA's Regional Counsels and OSC to facilitate the OSC review of complaints;

- The annual ethics training plan has been augmented to incorporate whistleblower protections;

- Annual notices are issued by senior VA officials to all employees each Spring as reinforcement of the Department's views;

- A videotape of a satellite broadcast, "Whistle-blowing: Rights, Remedies, and Rewards," has been publicized and made available to all facilities. The broadcast was presented on September 16, 1999, by the Office of General Counsel, the VA Learning University, and the Office of Special Counsel. Both the Special Counsel and General Counsel personally participated in the broadcast;

- A database has been established which will serve as a tool to help assess whether additional steps are needed to ensure that reprisal is not tolerated. The database will contain information, to the extent feasible, on the disposition of all whistle-blower complaints of which VA officials are aware, as well as corrective actions taken; and

- A nationwide ethics-training program was conducted in the fall of 2000. It included a segment on whistle-blowing.

B. Actions Currently Under Development or Planned for the Future

- We have developed language to be included in the Employee Handbook regarding whistleblower protections. The target date for issuance of the handbook is Spring 2001; and

- We will analyze the overall effectiveness of VA's actions (begin Summer 2001).

BUDGET IMPLICATIONS:

- There are routine costs associated with the issuance of annual notices to all employees by senior officials and costs associated with the establishment of rapid response teams.

- The only non-routine costs will be associated with analyzing the effectiveness of VA's actions. While the actual method for gathering needed information has not yet been determined, one of the methods under consideration is a survey of employees. It is estimated that this approach would cost approximately $15,000.

5. DISABLED VETERANS' CARE: Better Data and More Accountability Needed to Adequately Assess Care (GAO/HEHS-00-57), April 21, 2000:

RESPONSIBLE ORGANIZATION: Veterans Health Administration

RECOMMENDATION:

To help ensure compliance with the law, GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Health to assign lead responsibility to a headquarters unit for:

- Initiating efforts to monitor and determine the causes for apparent declines in capacity.

ACTION TAKEN:

- On November 2, 2000, the Under Secretary assigned E. M. Travers, MD, MHA to coordinate efforts in VHA to monitor capacity management activities and elucidate the causes for apparent declines in capacity to care for veterans with special disabilities.

RECOMMENDATION:

- Developing job performance standards for employees who are responsible for allocating and managing the resources used to serve veterans with special disabilities.

ACTION TAKEN:

- VHA's Office of the Chief Network Officer has chosen the Network Director's, Clinical Manager's, and Network Chief Financial Officer's currently assigned job performance standards as the appropriate standards to use for "employees who are responsible for allocating and managing the resources used to serve veterans with special disabilities" as stated in the original Action Plan.

BUDGET IMPLICATIONS:

- Since the Clinical Manager traditionally oversees the care management and quality management of the VISN's clinical specialties and does not allocate resources, the Chief Fiscal Officer for each VISN is the most logical employee to assign the responsibility of allocating and managing the resources used to serve veterans with special disabilities.

6. VETERANS' BENEFITS: Promising Claims-Processing Practices Need to Be Evaluated (GAO/HEHS-00-65), April 7, 2000:

RESPONSIBLE ORGANIZATION: Veterans Benefits Administration
Assistant Secretary for Policy and Planning

RECOMMENDATION:

While VBA has taken some steps to identify potentially promising practices, it has neither followed up on this effort nor developed a system for evaluating such practices and disseminating the results to regional offices. While regional offices reported a variety of practices they believe have helped improve their claims-processing performance, regional office and VBA officials agreed that it would be beneficial if VBA evaluated and identified best practices so that regional offices could use their limited resources to try only the most promising practices. Although VBA officials told us they are in the initial stages of planning a system for evaluating promising practices, VBA had not established specific timeframes for developing and implementing such a plan.

ACTIONS TAKEN:

In recent years VBA has developed systems and mechanisms for evaluating practices used by its field facilities. A prime example is the establishment of the Business Process Reengineering (BPR) case management demonstration sites. These sites by their very nature are test beds for best practices. Within the six identified sites, initiatives designed to improve claims processing are tested prior to nationwide implementation.

These demonstration sites are modeling the case management service process to include: defining and implementing this process; testing PC-based case management tools; and developing and utilizing a series of reader-focused writing letters that provide customers with process expectations, evidence needs, and claims status. They are also measuring the impact of this approach on claims processing by tracking a number of processes and service indicators including timeliness, accuracy, customer satisfaction, employee satisfaction, pending workload, and telephone service. After careful testing and evaluation, the initiatives are considered best practices and are rolled out to other stations.

The following represents a number of initiatives that were developed and tested locally in the field. Based on the merits of these local efforts, the concepts were developed, evaluated, and are being (or about to be) implemented nationally.

- Training, Responsibility, Involvement in the Preparation of Claims (TRIP)

- Personnel Information Exchange System (PIES)
- SSA Link
- CURR (DoD's Center for Unit Records Research) Link
- Compensation and Pension Record Interchange (CAPRI)
- Expectation Letter
- Case Management
- Veterans Service Representative (VSR) Position
- Veterans Service Center (VSC)
- National Automated Response System (NARS)
- Reader Focused Writing (RFW)
- Decision Review Officer (DRO)
- Skills Matrix
- Claims Adjudication Processing System (CAPS)
- Balanced Scorecard Utilization

Another initiative designed to evaluate and report on best practices is VBA's Virtual VBA lab at its regional office in Washington, DC. This lab is testing a paperless claims folder process that will ultimately result in a controlled roll out to other stations.

Other initiatives aimed at evaluating and disseminating best practices are VBA's telephone strategy, which is described in detail in VBA's semi-annual BRP report, and quality improvement plans and best practices.

As new initiatives are implemented, their impact is measured through the monthly Balanced Scorecard. The scorecard is also used to monitor performance nationwide through on-going VBA Leadership meetings. The Office of Field Operations holds regular conference calls with each of the Service Delivery Networks (SDNs) to discuss quality improvement efforts, to include best practices.

Earlier this year, VBA developed a process for the dissemination and implementation of best practices that stem from efforts at the local level, i.e., grass roots initiatives. Further development of the associated evaluation process at the local and national levels is underway. This process is being developed in coordination with the Office of Field Operations (OFO) and the program services. The focus of the process is to evaluate and disseminate for implementation locally developed initiatives that can demonstrate real improvements.

The best practice evaluation process will begin at the local level where the initiative is initially implemented. Applying an appropriate evaluation methodology, the station will assess the effectiveness of the practice on improving business operations. A defined format will be utilized for reporting best practices to include a description

of the practice, operation impacts (scorecard), policy and procedure impacts, cost, resource requirements, and lessons learned.

Upon review and approval as a best practice, the initiative will be posted on VBA's intranet site. Best practices will be publicized further on the Office of Field Operation's hotline calls. Initiatives demonstrating high impacts may be evaluated further via the BPR demonstration sites and adopted as a mandatory practice nationwide.

BUDGET IMPLICATIONS: None.

RECOMMENDATION:

To help ensure that VBA proceeds expeditiously, GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Benefits to establish timeframes for development and implementation of a formal plan for evaluating and disseminating information on practices that hold promise for improving the claims-processing performance of regional offices nationwide. The Secretary should also consider including information on goals for and results of disseminating information on promising practices in the annual reports submitted under Government Performance and Results Act (GPRA).

ACTIONS TAKEN:

The VA Strategic Plan for 2001-2006 includes a section on Program Evaluation. This section includes a six-year schedule for evaluations. We are in the process of developing a statement of work for the Pension and Parents Dependency and Indemnity Compensation (DIC) program evaluation scheduled for 2001. Disability Compensation is scheduled for evaluation beginning in 2002. While focusing primarily on outcomes, these evaluations will also assess the extent to which current performance (timeliness and accuracy) effects program outcomes.

BUDGET IMPLICATIONS: None.

7. VA AND DEFENSE HEALTH CARE: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies (GAO/HEHS-00-52), May 17, 2000:

RESPONSIBLE ORGANIZATION: Veterans Health Administration

RECOMMENDATION:

The Secretaries of VA and DoD should jointly assess how best to achieve the goals of health resource sharing, considering the changes that have occurred over the last decade in the VA and DoD health care systems and the populations they serve. This assessment should include a determination of the most cost-effective means of providing care to beneficiaries from the federal government's perspective – not just from the perspective of either VA or DoD. As part of this assessment, DoD and VA should determine the appropriate mix of purchasing care directly from contractors or providing care directly through their own systems, including medical sharing opportunities, by identifying current and expected excess capacities.

In addition, to the extent sharing opportunities and potential are identified, GAO recommends that the agencies jointly address the barriers that have impeded sharing and collaboration, by establishing procedures to accommodate each other's budgeting and resources management functions as well as facilitate timely billing, reimbursement, and agreement approval.

Finally, to increase the usefulness of the joint VA/DoD database as a means for assessing and reporting sharing progress to the Congress, GAO recommends that the Secretaries direct, respectively, the Under Secretary for Health and the Assistant Secretary of Defense (Health Affairs) to include in the joint database:

- The volume and types of services provided, reimbursements collected, and costs avoided under local and joint venture sharing agreements between VA and DOD facilities by having facilities report this activity to the medical sharing office; and
- Similar information on the progress and activity occurring under national initiatives and other sharing activities authorized outside of the Sharing Act.

To increase the attractiveness of VAMCs as cost-effective providers of services to DoD, GAO recommends that the Secretary of VA direct the Under Secretary for Health to ensure that VAMCs follow VA's guidelines and charge incremental costs rather than total costs under sharing agreements.

ACTIONS TAKEN:

- VA and DoD have resolved claims payment problems relating to the treatment for traumatic brain injury and spinal cord injury, as well as blind rehabilitation of active duty personnel.

- A VA-DoD Financial Committee has met several times and has settled on the amounts owed VA when DoD converted supplemental care to TRICARE. Payment instructions to military hospitals from DoD and VHA billing instructions to VAMCs will be issued shortly.

- VA has appointed one of its senior personnel, the Director of the VA Health Administration Center in Denver, to serve as liaison with the TRICARE Management Office in Aurora, Colorado, to facilitate the resolution of issues associated with VA and TRICARE contractor relationships.

- An existing DoD contract has been modified to incorporate the review and evaluation of all VA-DoD sharing agreements as required by the forthcoming FY 2001 Defense Authorization Act. The review of these agreements and the associated database began on November 1, 2000, and is targeted for completion October 31, 2001.

- The VA and DoD have met several times in an attempt to create a mutually acceptable memorandum of understanding to implement Section 113 of the Veterans Millennium Health Care and Benefits Act that provides for DoD reimbursement to VA for treatment of TRICARE beneficiaries. However, ambiguities in the statutory language, and other implementation issues have delayed agreement. In addition, the National Defense Authorization Act of 2001 authorized the TRICARE for Life program under which military retirees eligible for Medicare would be able to receive care from any Medicare provider with TRICARE paying all Medicare co-pays (resulting in free health care). The Administration has included appropriation language in the DoD's budget that would require military retirees to annually choose either VA or DoD as their health care system. This will allow for more accurate budgeting and foster better quality of care through coordination of services. This provision also negates the need for the Section 113 TRICARE program.

BUDGET IMPLICATIONS: VA will regain an unspecified amount of money owed by DoD when DoD and VA provide billing and collection instructions to military and VA medical facilities to recover money owed VA. Because of a lack of instructions when DoD converted supplemental care to TRICARE, VA facilities were paid at rates lower than agreed to in VA-DoD sharing agreements or not paid at all.

8. VETERANS' HEALTH CARE: VA Needs Better Data on Extent and Cause of Waiting Times (GAO/HEHS-00-90), May 31, 2000:

RESPONSIBLE ORGANIZATIONS: Veterans Health Administration

RECOMMENDATION:

GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Health to first determine the extent waiting times and their causes and then develop a spending plan that will result in solving the identified waiting time problems.

ACTIONS TAKEN:

- VHA's overall service and access goal is to provide medical care when and where it is needed in ways that are timely, convenient, and cost-effective. Timeliness of service ensures that medical care is received when it is needed.

- A significant aspect of increasing access to VA medical care is VHA's focus on its "30/30/20" performance measures. The purpose of these measures is to identify how long it takes veterans to obtain appointments for non-urgent care and how long it takes them to see a provider after arriving at VA facilities for scheduled appointments. VHA has a number of initiatives in place to address these waiting time performance goals. Although VHA has made significant improvements in waiting time performance, there remains a complexity of problems that VHA must confront as it looks at further needed improvements. VHA's waiting time measures are dynamic.

- Performance goals for 2002 are based on both the performance of 2001 and funding provided for 2002. Goals for 2002 are ambitious, yet realistic "stretch-goals," appropriate to achieving the ultimate stretch-goal of 30/30/20 in the target time. This goal is stated as a three-year target, with 2003 being the year for its attainment. Specifically, VHA's goals by 2003 are as follows:

    - To see 90% non-urgent primary care patients within 30 days;
    - To see 90% non-urgent specialty care referrals within 30 days; and
    - To see 90% of patients within 20 minutes of scheduled appointment time. (Currently, emergencies and urgent care needs are met immediately.)

- VHA thinks these goals are aggressive and support patient expectations for timely access to care. There is no uniform community standard for the benchmark. Further, a recent survey of university medical centers addressing expected availability of non-urgent primary and specialty care appointments found no consistent definition of acceptable waiting times and no consistent mechanism for validating the relationship between expectations and actual practice.

- In terms of actual performance, VHA has already made significant system-wide improvements. Performance measures indicate decreases in average clinic waiting times from April 2000 to December 2000.

- VHA is in the negotiation phase with the Institute of Healthcare Improvement (IHI) on a major initiative that will focus on spreading changes to the six clinics highlighted in the Network Performance Plan (Orthopedics, Urology, Cardiology, Audiology, Primary Care, and Eye Care). IHI will work VHA to (1) enhance, strengthen, and redirect, if needed, the current spread of activities underway within each VISN to achieve the 30/30/20 performance targets; and (2) develop a prototype infrastructure for managing the spread of innovation based on the National Access and Wait Times Spread Initiative that can be applied to other clinical and operational topics.

- VHA also has the following initiatives in place to address waiting time performance goals:

    - Additional staff have been hired in critical areas to provide more timely access to care and services.

    - More community-based outpatient clinics have been opened to provide improved and more convenient access to patients.

    - Short-term contracts have been procured with specialists to provide services to veterans who have been waiting for a significant period of time.

    - Infrastructure in existing facilities has been renovated to ensure that at least two exam rooms are available for those providing services on a given day.

    - The availability of mental health services, including Post-Traumatic Stress Disorder (PTSD) and substance abuse services in facility- and community-based outpatient clinics, has been increased to improve mental health access and service.

- Transplant sharing agreements have been developed to increase access and decrease costs.

- New diagnostic and treatment equipment has been purchased and aging equipment has been replaced to improve clinical services.

- Aging linear accelerators and cardiac catheterization laboratories have been replaced to improve clinical services.

- Outpatient medication dispensing technology has been provided in community-based outpatient clinics and hospital-based clinics to improve service.

- An infusion of resources to facilities in order to target local initiatives intended to correct identified causes for delays.

RECOMMENDATION:

In addition, VA should develop a mechanism for monitoring and tracking expenditures for improving timeliness to evaluate how well targeted funds have reduced waiting times.

ACTIONS TAKEN:

- As part of the Network Financial Plan submissions, a spending plan for Access and Service Delivery is required. This Spending Plan identifies the planned expenditures and progress that would result from the proposed expenditures in improving waiting times. These are planned expenditures and the implementation of initiatives and resulting improvements would be largely dependent on the resources available. The Office of Quality Assurance with periodic reviews of the database does the actual monitoring of improvements.

BUDGET IMPLICATIONS: The 2002 budget includes an increase of $164 million and 1,094 FTE for access and delivery of services.

9. INFORMATION TECHNOLOGY: VA Actions Needed to Implement Critical Reforms (GAO/AIMD-00-226), August 16, 2000:

RESPONSIBLE ORGANIZATIONS: Office of the Assistant Secretary for Information and Technology

RECOMMENDATION:

Timely in-process reviews are a key component of the Information Technology (IT) decision-making process and assist VA in controlling approved projects. GAO therefore recommends that VA take action to improve VA's IT investment decision-making process by:

- Establishing and monitoring deadlines for completing formal in-process reviews at key milestones in a project's life cycle.

ACTIONS TAKEN:

- A statement of work has been developed that is being used to obtain contractor support for VA's enhanced review program. This enhanced review program will better support VA's capital investment process and respond to the requirements mandated by various Congressional and governmental regulations.

RECOMMENDATION:

- Providing decision-makers, such as investment panel members, with information on lessons learned from post-implementation reviews of IT projects so that they can use such data in making better informed judgments about projects.

ACTIONS TAKEN:

- At the completion of each post implementation review, the findings and lessons learned by the project office will be provided to VA's decision-makers. The supporting analyses will be used to assist in making VA IT investment portfolio decision. Lessons learned help VA decision-makers to modify future selection and control decisions and make better use of VA resources.

RECOMMENDATION:

- Developing and implementing guidance to better manage IT projects below the Capital Investment Board (CIB) threshold.

ACTIONS TAKEN:

- The VA Information Technology Investment Guide was published and a training workshop was conducted. This guide provides in detail VA's approach to managing all of its IT investments, including projects which are in the process of development and implementation.

RECOMMENDATION:

Full implementation of key provisions of the Clinger-Cohen Act is required by law and provides a foundation for an agency's effective use of IT. GAO therefore recommends that VA take action to ensure that VA fully addresses these key provisions by:

- Filling the position of Assistant Secretary for Information and Technology as quickly as possible to provide the needed leadership to achieve the *One VA* vision.

ACTIONS TAKEN:

- Until the appointment process is complete, the Acting Assistant Secretary for Information and Technology will be the Acting CIO.

RECOMMENDATION:

- Reassessing VA's decision to delegate business process reengineering to the individual Administrations.

ACTIONS TAKEN:

- VA expects the Department-wide Enterprise Architecture to assist its organizations in identifying and defining opportunities for business processing reengineering.

RECOMMENDATION:

- Directing the department's CIO or designee to lead the effort and work with VA business owners to develop a logical architecture as a step toward an integrated IT architecture.

ACTIONS TAKEN:

- The CIO is taking the lead in sponsoring the development of a Department-wide Enterprise Architecture. The development of the architecture has the support of the CIO Council members and the input of VA's business owners is an important element in its development. Once the initial Enterprise Architecture is complete, VA plans to concentrate on an in-depth analysis of its business process and information flow.

BUDGET IMPLICATIONS:

- Immediate budget implications focus on funding for contractor support to develop the Department-wide Enterprise Architecture. Long-term implications are likely to focus on the Administration and staff offices' efforts related to the elimination/consolidation of duplicate systems and obtaining systems to meet identified business needs to conform to the architecture.

- Funding for contractor support for expanding the review program has been obtained. Long-term funding requirements will be necessary to future strengthen VA's review program and the capital investment process.

10. OLYMPIC GAMES: Federal Government Provides Significant Funding and Support (GAO/GGD-00-183), September 8, 2000:

RESPONSIBLE ORGANIZATION: Office of the Assistant Secretary for Management

RECOMMENDATION:

To enable Congress, the executive branch, and other interested parties to identify and monitor the total amount and type of federal funding and support planned for and provided to the Olympic Games when they are held in the United States, GAO recommends that the Administrator of GSA and the Secretary of VA direct the appropriate officials at their respective agencies to effectively implement policies and controls to ensure that federal funds for the Olympic and Paralympic Games hosted in the United States are used for the appropriate purposes in accordance with the underlying policies, and agreements. In commenting on a draft of this report, the White House Task Force on the 2002 Winter Olympic and Paralympic Games suggested that GSA and VA consult with OMB on Olympic-related funding issues.

ACTIONS TAKEN:

- VA has worked with Appropriations Subcommittee staff and OMB to ensure federal funds for the upcoming Olympic and Paralympic Games are used appropriately. In advance of final congressional action on VA's 2001 appropriations bill and at the request of committee staff, VA sent a letter to the Senate and House Chairs of the VA, HUD and Independent Agencies Appropriations Subcommittee requesting authority to spend up to $2 million of 2001 funding in support of the 2002 Paralympic Games. OMB was provided a copy of the letter. Congress subsequently limited the amount to $250 thousand to support the Sixth International Paralympic Committee Scientific Congress on "Sport and Human Performance Beyond Disability." In the Conference Report accompanying VA's 2001 Appropriations Bill, Congress included language allowing VA to spend funds from the Medical Care account for this purpose. The conferees believe this activity is consistent with VA's mission.

- VA will also expend funds on security modifications for the Medical Center in Salt Lake City.

BUDGET IMPLICATIONS: VA will track these costs and abide by the Committees' instruction. The following funding is reported in the President's Budget under the Medical Care account for the 2002 Winter Olympics and Paralympic Committee Scientific Congress:

	FY 2000	FY 2001	FY 2002	Total
Security modifications	$2,124,000	$168,000	$618,000	$2,910,000
Paralympic Medical Congress		$250,000		

11. VA INFORMATION SYSTEMS: Computer Security Weaknesses Persist at the Veterans Health Administration (GAO/AIMD-00-232), September 8, 2000:

RESPONSIBLE ORGANIZATION: Office of the Assistant Secretary for Information and Technology

RECOMMENDATION:

GAO recommends that the Acting Secretary of Veterans Affairs direct the acting VA CIO to work with the VHA CIO and medical facility directors as appropriate to:

- Ensure that the remaining computer security weaknesses at each health care system we visited, which are summarized in appendix II, are corrected in accordance with the action plans developed by each of the medical facilities and detailed in our separate reports to the facility directors; and

- Provide security oversight resources as prescribed in VHA policy to effectively implement and oversee VA's computer security management program through risk, implementing policies and controls, promoting awareness, and evaluating the effectiveness of information system controls at VHA facilities.

In addition, to facilitate the development of detailed Department-wide guidance and oversight processes relating to key aspects of computer security programs, such as assessing risk, monitoring system and user access activity, and evaluating the effectiveness of information system controls, as GAO recommended in October 1999, and reaffirmed in GAO conclusions above, GAO recommends that the Acting Secretary of Veterans Affairs direct the acting VA CIO to implement a cooperative process across all VA component offices that would identify and, where appropriate, integrate security guidance developed by VA components.

ACTIONS TAKEN:

- VA's Departmental Information Security Working Group collaborates to develop Department-wide policy, guidance and processes. This Working Group is comprised of all Administration and staff office security management offices. The Working Group operates under the guidance, and reports to, VA's CIO Council. Policies that are proposed for issuance Department-wide are submitted to the CIO Council for approval, and are processed through VA's formal Directives Management System. These management controls assure those Department-wide security policies, procedures, and processes are thoroughly and equitably vetted.

RECOMMENDATION:

GAO also recommend that the Acting Secretary of Veterans Affairs direct the Acting VA CIO to monitor and report to the Acting Secretary for resolution issues, such as an administration's lack of commitment of resources to the Department-wide program, that could affect the development and implementation of VA's Department-wide computer security program.

ACTIONS TAKEN:

- VA has several management reporting processes in place to assure that security program issues, in particular those of a financial nature, are addressed. Principally, these processes include the capital investment execution review process, VA's Strategic Management Board quarterly review, FMFIA Material Weaknesses Program reviews, and monthly meetings of VA's CIO Council.

- On February 7, 2001, the CIO briefed Secretary Principi on the Information Security Program.

BUDGET IMPLICATIONS: The budget basis for the Department program is consistent VA now that VA has a funded capital investment plan.

12. VA RESEARCH: Protections for Human Subjects Need to Be Strengthened (GAO/HEHS-00-155), September 28, 2000:

RESPONSIBLE ORGANIZATIONS: Veterans Health Administration

RECOMMENDATION:

To strengthen VA's protections for human subjects, GAO recommends that the Acting Secretary of Veterans Affairs direct the Under Secretary of Health to take immediate steps to ensure that VA medical centers, their institutional review boards (IRBs) –whether operated by VA or not – and VA investigators comply with all applicable regulations for the protection of human subjects by:

- Providing research staff with current, comprehensive, and clear guidance regarding protections for the rights and welfare of human research subjects; and
- Providing periodic training to investigators, IRB members, and IRB staff about research ethics and standards for protecting human subjects.

ACTIONS TAKEN:

- VA's Office of Research Compliance and Assurance (ORCA) now has a full complement of staff in headquarters. ORCA has also hired a Regional Office Director for the Chicago office and several support positions. Other hiring is imminent.
- ORCA's second Field Advisory Committee met in Washington, DC, on January 17 and 18, 2001, and continued to review ORCA's actions to follow up on GAO's findings and recommendations.
- ORCA is working with its contractor to develop a template for Standard Operating Procedures for Institutional Review Board and critique of extant procedures at several Veterans Affairs Medical Centers.
- ORCA has completed the first phase of its Multi-Assessment Program (MAP) protocol, i.e., oversight of human subjects protections program, and has conducted the first pilot program on January 28 through February 1, 2001, at the Edward J. Hines VA Medical Center. MAP review teams will complete two more pilot visits in February and March 2001, and the MAP Committee will meet again in March to evaluate, refine instruments, and expand the reviews to research misconduct, animal welfare, and bio-safety mandates.
- The Office of the Chief Research and Development Officer (ORD) continues to work closely with the National Committee for Quality Assurance (NCQA) to establish standards for accreditation of human research protection programs. The accreditation standards are now in a third draft, and one pre-test has been completed. We are currently conducting a second pre-test, and standards are

being finalized. We expect to implement the finalized accreditation process in July 2001.

- ORCA continues to work with ORD and NCQA in development of the Human Subject Accreditation plan for VA.
- ORD has drafted the handbook "Human Research Subject Protections" which is currently in the VA concurrence system. A copy of the draft copy can be accessed at ORD's Web site.
- ORCA is developing guidance for the Federal-wide Assurance Program initiated by the Office of Human Research Protections (OHRP) that VA will use for its assurance system. This system will replace a variety of OHRP assurance mechanisms and VA's Multiple Project Assurance Contract.

RECOMMENDATION:

- Developing a mechanism for handling adverse event reports to ensure that IRBs have the information they need to safeguard the rights and welfare of human research participants.

ACTIONS TAKEN:

- ORCA has established a focus group concerning Adverse Events in Research. The primary role of the group is to advise and assist ORCA on all matters related to the protection of human subjects who experience adverse events during their participation in research studies at VA Medical Centers and/or supervised by VHA personnel. The group includes representation from Federal offices both within and outside of VA. This group will have its first meeting in March 2001, and will carefully consider the recommendations in GAO's report.

- ORCA has conducted several compliance visits and sponsored or participated in several education site visits since December 2000.

RECOMMENDATION:

- Expediting development of information needed to monitor local protection systems, investigators, and studies and to ensure that oversight activities are implemented.

ACTIONS TAKEN:

- ORCA will present its strategic plan for training, education, and development (TED) for approval in VHA Headquarters and will re-charter its focus group on TD in the coming weeks. ORCA continues to participate in the OHRP/FDA/VA

jointly sponsored workshops and town meetings and also plans a VISN-wide pilot of a program in human subjects protections for senior leadership to be held in March 2001 for one of the VISNs. Upon evaluation, this program may be extended to other ORCA Regional Offices or VISNs later this year.

RECOMMENDATION:

- Determining the funding levels needed to support human subject protection activities at medical centers and ensuring an appropriate allocation of funds to support these activities.

ACTIONS TAKEN AND BUDGET IMPLICATIONS:

- ORD has commissioned a study through the Health Services Research and Development Service (HSR&D) to determine the costs of operating effective IRBs. HSR&D will complete its survey of all 120 centers that conduct human research in February 2001, and then conduct pilot testing at several sties. ORD expects to complete the project by September 2001.